6 Women's Health Initiative

6.2 Women's Health Initiative Eligible Practices

An eligible Women's Health practice is a medical practice or clinic that is:

- a gynecology, maternal-fetal medicine, obstetric, reproductive health, or family planning medical practice, specializing in providing women's health preventive services as defined by the American Congress of Obstetricians and Gynecologists (ACOG); OR
- a mixed practice or clinic that employs at least one board-certified obstetric or gynecology provider whose primary scope of practice is women's preventive services as defined by ACOG.

A Women's Health Initiative (WHI) practice has agreed to participate in the initiative and has attested to meeting the criteria listed above and to implementing the WHI program requirements listed in section 6.3 below.

6.3 Patient Attribution & Enhanced Payments for the Women's Health Initiative

WHI practices shall receive three (3) Blueprint-specific forms of payment from the Blueprint's WHI-participating insurers, or payers, to support the provision of high-quality women's health primary care and well-coordinated health services:

1. Recurring per member per month (PMPM) payments to WHI practices
2. Recurring payments to support WHI Community Health Team (CHT) staff to the CHT administrative entities
3. A one-time per member payment (PMP) to support stocking of Long Acting Reversible Contraceptive (LARC) devices to WHI practices.

The WHI payments are made directly to WHI practices or Community Health Team entities, contingent on the WHI practices' attestation of 1) meeting program eligibility requirements outlined in the self-attestation document and 2) meeting program participation requirements. In effect, the PPPM payments support enhancing the quality of services provided by the practice as assessed by the WHI program participation requirements, which are:

- Within one (1) month of receiving the PMP, the WHI practice will stock the full spectrum of LARC devices at a level adequate for the practice size, ensuring the availability of same-day insertions for women who choose LARC as their preferred birth control method. The minimum number of stocked LARC devices shall be proportional to the number of patients served by the practice, as outlined in the table below:

Number of WHI Patients	Minimum Number of Devices
up to 300	at least 5 devices, including 2 of hormonal IUD, 2 non-hormonal IUD, and 1 implant

Number of WHI Patients	Minimum Number of Devices
300-499	at least 6 devices, including 2 hormonal IUD, 2 non-hormonal IUD, and 1 implant
500-699	at least 9 devices, including 2 hormonal IUD, 2 non-hormonal IUD, and 1 implant
700-799	at least 12 devices, including 2 hormonal IUD, 2 non-hormonal IUD, and 1 implant
800-999	at least 15 devices, including 2 hormonal IUD, 2 non-hormonal IUD, and 1 implant
1000-1199	at least 18 devices, including 2 hormonal IUD, 2 non-hormonal IUD, and 1 implant
1200-1299	at least 21 devices, including 2 hormonal IUD, 2 non-hormonal IUD, and 1 implant
1300 or greater	at least 24 devices, including 2 hormonal IUD, 2 non-hormonal IUD, and 1 implant

- Within the first three (3) months of WHI CHT and PMPM payments starting, the WHI practice will develop and implement policies and procedures for screening, brief intervention, and referral for depression, intimate partner violence, and substance abuse.
- Within the first three (3) months of WHI CHT and PMPM payments starting, the WHI practice will update and/or implement a policy and procedure for evidence-based, comprehensive family planning counseling.
- Within the first six (6) months of WHI CHT and PMPM payments starting, the WHI practice will develop and implement a policy and procedure to provide same-day insertion for those women who choose LARC as their preferred birth control method.
- Within the first twelve (12) months of WHI CHT and PMPM payments starting, the WHI practice will develop referral protocols and written agreements with at least three (3) community based organizations to see patients within one (1) week of being referred for family planning services. At that visit, the WHI practice will provide same-day availability for the full spectrum of birth control options, including LARC devices.
- Within the first twelve (12) months of WHI CHT and PMPM payments starting, the WHI practice will develop a referral protocol and written agreement with at least one (1) patient-centered medical home (PCMH) primary care practice to accept patients identified as not having a primary care provider.
- Within the first eighteen (18) months of WHI CHT and PMPM payments starting, the WHI practice will develop and implement policies and procedures to screen for access to a primary care provider/PCMH, food insecurity, and housing insecurity and to refer to services in the event of a positive screen.

6.4 Women's Health Initiative (WHI) Payments

The enhanced payments for WHI practices in conjunction with additional CHT funding aim to support practices in providing well-coordinated preventive women's health services for all female patients aged 15 – 44 years.

The following outlines the attribution model used for all three forms of WHI payments.

The Blueprint will provide payers with practice roster information received from all WHI practices. Payers will use the practice roster information to calculate claims-based Blueprint patient attributions for each WHI practice, as specified in Appendix 7, for validated WHI providers.

Validated WHI providers are eligible providers, including physicians (MDs and DOs), advanced practice registered nurses (nurse-practitioners and certified nurse midwives), and physician assistants, who either:

- Work in a gynecology, maternal-fetal medicine, obstetric, reproductive health, or family planning medical practice that provides women's health preventive services as defined by ACOG; OR
- Work in a mixed-specialty practice as a board-certified obstetric or gynecology provider whose primary scope of practice is women's health preventive services as defined by ACOG.

The enhanced payments for WHI practices and additional CHT funding are based on the number of total unique WHI-attributed patients to the practice and to validated WHI providers by each WHI-participating insurer. The attribution methodology used by all WHI-participating insurers determines the practice's active WHI caseload. Insurers will attribute all patients having a majority of their women's preventive health visits with the practice's WHI-rostered providers in the last 24 months. Payment is contingent on the WHI practice's completion of the program participation requirements as outlined above.

The definition of a "current active WHI patient" is as follows: The patient must be female aged between 15 and 44 years (inclusive). The patient must have had a majority of their women's preventive health visits in the WHI practice within the 24 months prior to the date that the attribution process is being conducted, in accordance with the algorithms presented in Appendix 7 (for practice self-reports) and Appendix 8 (for insurers). If a patient has an equal number of qualifying women's preventive health visits at more than one WHI practice, then that patient will be attributed to the WHI practice with the most recent visit. Patient attributions for members of Blueprint WHI-participating self-insured plans will be included. Attribution is to be refreshed at least quarterly.

Upon request of the practices, clinics, or their parent organizations, payers will provide the list of attributed patients for review and reconciliation. Each insurer will send a list of the number of attributed patients to each WHI practice (or parent organization) when the attribution is first conducted and subsequently when it is recalculated. This process provides the opportunity for a WHI practice to reconcile differences with each of the

payers. To support an efficient and uninterrupted payment process, the insurer and practice should agree on the number of attributed patients within 30 days of the date when the insurer sends an attribution list to the practice in order.

Each WHI-participating insurer will also report attribution to the Blueprint. At the beginning of each calendar quarter (generally within 15 days of the start of each calendar quarter), each WHI-participating insurer will send to the Blueprint a list of the counts of WHI-attributed patients and WHI practice PMPM payments made for the prior calendar quarter for WHI practices broken out by practice (including Blueprint Practice ID) and payment month. This reporting will enable payment verification and rollups across payers at the practice and Health Service Area (HSA) levels.

The attribution methodology found in Appendix 7 (for practice self-reports) and Appendix 8 (for insurers) are the current models generated in collaboration with the Women's Health Initiative Payment Implementation Work Group, and approved by consensus of the Blueprint Executive Committee. The attribution methodology can be revised after seeking input from the Blueprint's Payment Implementation Work Group, Expansion Design and Evaluation Committee, and Executive Committee. The WHI practice PMPM amounts can be revised by the Blueprint Director after seeking input from the Blueprint's Payment Implementation Work Group, Expansion Design and Evaluation Committee, and Executive Committee.

6.4.1 WHI Practice PPPM Payment Model

The WHI practice PMPM payment helps support the operations of a women's health preventive care practice or clinic including enhancing their scope of practice by implementing the WHI requirements. The total capitated payment to women's health providers is based on completion of the program participation requirements in the first year with the addition of performance-based quality and utilization components of the payment in subsequent years. The WHI-participating payer will provide the enhanced WHI practice PMPM payment for all WHI-attributed patients in the WHI practice.

To calculate the total amount of the WHI practice PMPM payment for each practice, the WHI-participating payer will multiply the number of WHI-attributed patients in the practice by the WHI practice PMPM amount.

For the first twelve (12) months of participation in the program, WHI practices will be paid a $1.25 PMPM maximum capitated payment. Starting the second year of participation in the program, WHI practices will be paid a base payment of $1.00 PMPM, based on their self-attestation. Additionally, a WHI practice could earn a quality payment of up to $0.50 PMPM based on performance measures and utilization measures. The outcome measures driving the performance component in the second and subsequent years are yet to be determined and will include a combination of measures at the community and practice level.

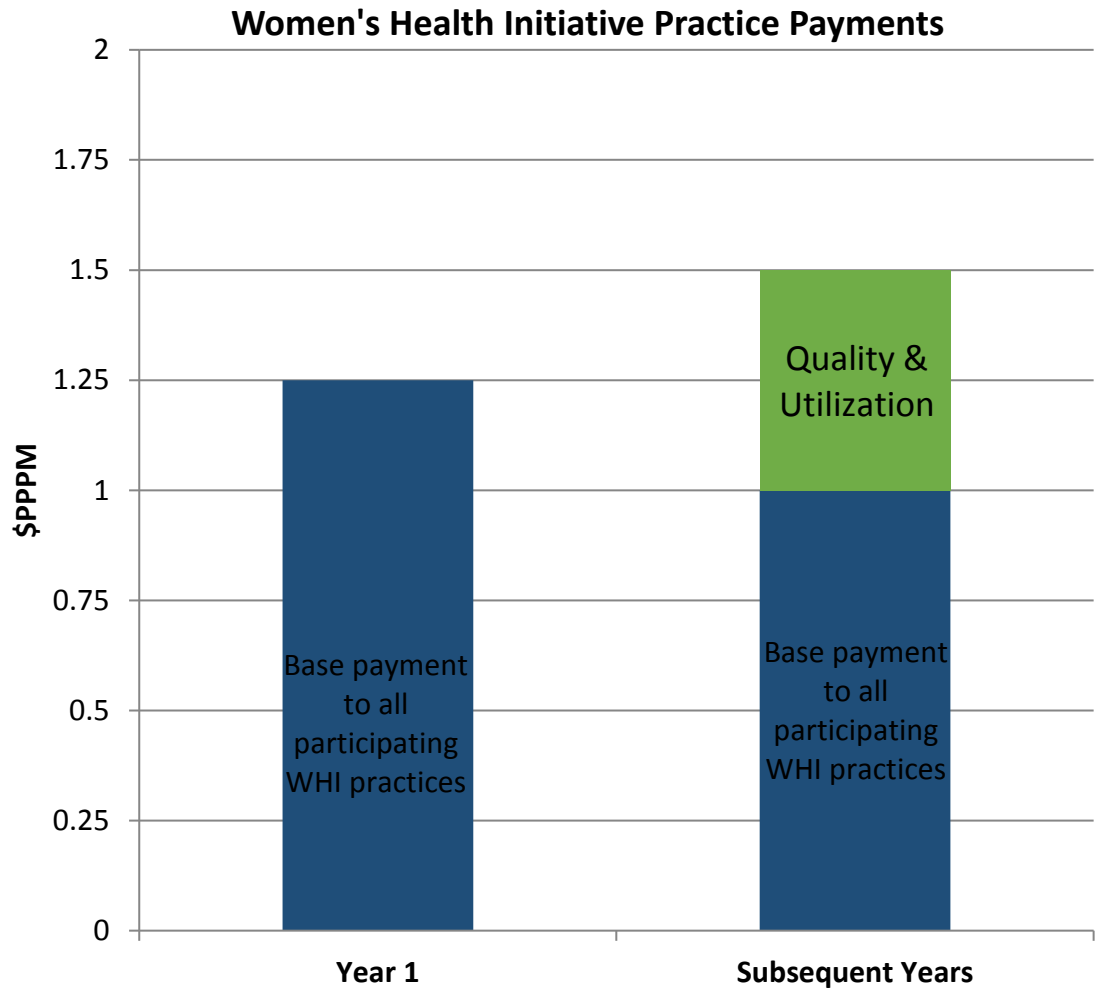
The new women's health preventive services model for Medicaid and commercial insurers includes the following elements:

- Base Component: First year of participation (Pilot Year) = $1.25; Subsequent Years = $1.00
    - Requires successful completion of the self-attestation eligibility document
    - Requires successful completion of the program participation requirements, outlined in section 6.3 of this document

- Quality and Utilization Performance Component (Year 2 and subsequent years):
    - Up to $ 0.50 PPPM

- Total Payment in Year 1 = $1.25
- Total Payment in Subsequent Years = $1.00 + Quality and Utilization Index
- Total Payment in Subsequent Years ranges from $1.00 to $1.50 PMPM

Figure 3. Women's Health Initiative (WHI) Practice Payments



WHI practice PMPM payments will be sent directly to the practice, clinic, or parent organization. Payment for new practices or practices rejoining WHI will be effective on the first day of the month following the date when the Blueprint transmits confirmation of receipt of the self-attestation document to all WHI-participating payers. Changes in payment resulting from subsequent changes in scores from the quality-of-care measures and/or the utilization measure will be implemented by all WHI-participating payers on the first day of the month after scores are received by all WHI-participating payers from the Blueprint.

6.4.2 Supplemental Community Health Team (CHT) Payments

Supplemental CHT payments augment existing CHT staff with licensed mental health professionals to work in WHI practices. The WHI-participating insurers will share the costs associated with the supplemental CHT staffing and will send their share of CHT costs to the Administrative entity or entities in each HSA that are responsible for hiring CHT members.

Supplemental CHT payments are scaled based on the population of payer claims-attributed WHI patients per month.[1] To calculate the total amount of the WHI CHT PMPM payment for each CHT Administrative Entity, the WHI-participating payer will multiply the number of WHI-attributed patients in the practice by the WHI CHT PMPM amount. Commercial and Medicaid WHI-participating payers will pay $5.42 per payer claims-attributed member per month (PMPM).

The WHI-participating payers will make WHI CHT payments on the same schedule as the WHI practice payments.

CHTs under the same Administrative Entity within an HSA that are geographically dispersed throughout the HSA or otherwise segmented will be treated as a single CHT for payment purposes, regardless of the CHT's capacity and the number of WHI patients in WHI practices. If there is more than one Administrative Entity in the HSA, the CHTs for each administrative entity will be treated as individual CHTs for payment purposes. If more than one Administrative Entity exists in an HSA, each WHI practice in the HSA will be assigned to one CHT and one Administrative Entity. A WHI practice will not be split among Administrative Entities and CHTs.

6.4.3 One-time Capacity Payment Per-Member Payment (PMP)

The purpose of the capacity payment PMP is to assist WHI practices in initiating WHI participation requirements and specifically provides support to the practices in designing and implementing processes to provide evidence-based family planning counseling including the full spectrum of birth control options, stock LARC devices, and facilitate

[1] Supplemental CHT payments, and by extension the number of full time equivalent (FTE) supplemental CHT staff members, are intended to be equal to 1 FTE per $78,000 CHT payments based on an average licensed mental health professional yearly salary or 1 FTE per every 1,200 patients.

offering patients who choose LARC as their preferred birth control method same-day availability for LARC insertion. The WHI-participating insurers will share the costs associated with the capacity payment and will send their share of the costs directly to the WHI practices.

To estimate the size of the patient population served by the upfront capacity payment for each WHI practice, WHI-participating payers will calculate and report the number of active WHI-attributed patients seen in WHI practices in the previous two years as defined in section 6.4.

All WHI-participating payers will share in the cost, proportional to their share of the payer-reported, claims-attributed, WHI patient population (claims-attributed total unique WHI patients). WHI patient volume and WHI-participating payer contribution proportions will be derived from the attribution, and WHI payment reports submitted preceding a Women's Health Initiative initiation date for a WHI practice.

The capacity payment is a one-time per member payment (PMP) based upon a floor of stocking at least two hormonal and two non-hormonal IUDs, and 1 implant. These 4 IUDs, two hormonal and two non-hormonal, in addition to 1 implant comprise the minimum stocking requirement for WHI practices. The floor or minimum payment value of the PMP regardless of attributed lives is $927 for Medicaid 340B eligible practices and $5,163 for non-Medicaid 340B eligible practices. There is a ceiling based on covering the costs of stocking at least 8 of each device, yielding a total of 24 devices for each WHI practice. The ceiling or maximum payment value of the PMP regardless of attributed lives is $3,387 for Medicaid 340B eligible practices and $16,184 for non-Medicaid 340B eligible practices. WHI practices that receive payment for more than 2 IUDs of each type and the 1 implant have the flexibility to choose among the available options to fulfill the needs of their patients after stocking the minimum requirement.

The capacity payment PMP amount is a graduated rate based on whether a practice is Medicaid 340B eligible. The capacity payment PMP is scaled based on the population of payer claims-attributed WHI patients in the 24-month lookback period preceding a WHI practice initiation date. Commercial and Medicaid WHI-participating payers will pay a $4.42 per member payment for Medicaid 340B eligible WHI practices or a $11.87 per member payment for non-Medicaid 340B eligible WHI practices. The payer will make the capacity payment one time, as determined by the WHI initiation date set by the WHI practice.

APPENDIX 7
VERMONT BLUEPRINT PRACTICE
TOTAL UNIQUE VERMONT PATIENTS ALGORITHM

1. The look back period is the most recent 24 months for which claims are available.

2. Identify all female patients aged 15 to 44 years who are Vermont residents.

3. Identify the number of Vermont patients who had at least one visit to a primary care provider in the practice with one or more of the following qualifying CPT Codes during the look back period (most recent 24 months).

CPT-4 Code Description Summary
PCMH & WHI Codes
Evaluation and Management - Office or Other Outpatient Services • New Patient: 99201-99205 • Established Patient: 99211-99215
Consultations - Office or Other Outpatient Consultations • New or Established Patient: 99241-99245
Nursing Facility Services: • E & M New/Established patient: 99304-99306 • Subsequent Nursing Facility Care: 99307-99310
Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Service: • Domiciliary or Rest Home Visit New Patient: 99324-99328 • Domiciliary or Rest Home Visit Established Patient: 99334-99337
Home Services • New Patient: 99341-99345 • Established Patient: 99347-99350
Prolonged Services – Prolonged Physician Service With Direct (Face-to-Face) Patient Contact • 99354 and 99355
Prolonged Services – Prolonged Physician Service Without Direct (Face-to-Face) Patient Contact • 99358 and 99359
Preventive Medicine Services • New Patient: 99381–99387 • Established Patient: 99391–99397
Counseling Risk Factor Reduction and Behavior Change Intervention • New or Established Patient Preventive Medicine, Individual Counseling: 99401–99404 • New or Established Patient Behavior Change Interventions, Individual: 99406-99409

CPT-4 Code Description Summary
• New or Established Patient Preventive Medicine, Group Counseling: 99411–99412
Other Preventive Medicine Services – Administration and interpretation: • 99420
Other Preventive Medicine Services – Unlisted preventive: • 99429
Newborn Care Services • Initial and subsequent care for evaluation and management of normal newborn infant: 99460-99463 • Attendance at delivery (when requested by the delivering physician) and initial stabilization of newborn: 99464 • Delivery/birthing room resuscitation: 99465
Federally Qualified Health Center (FQHC) – Global Visit ***(billed as a revenue code on an institutional claim form)*** • 0521 = Clinic visit by member to RHC/FQHC; • 0522 = Home visit by RHC/FQHC practitioner • 0525 = Nursing home visit by RHC/FQHC practitioner
WHI Unique Codes
Asymptomatic Bacteriuria Screening in Pregnant Female • 87081, 87084, 87086, and 87088
Breast and Ovarian Cancer Susceptibility, Genetic Counseling and Evaluation for BRCA Testing • 96040
Breast Cancer Screening • 77052, 77055-77057, and 77063 • G0202
Breast Feeding Support, Supplies and Counseling • A4281-A4286 • E0602-E0604 • S9443
Cervical Cancer Screening • 88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, and 88175 • G0101, G0123, G0141, G0143-G0145, G0147, and G0148 • Q0091
Chlamydia Screening • 86631, 86632, 87110, 87270, 87490, 87491, and 87800
Contraceptive Methods • A4261, A4264, A4266, and A4268 • J7297, J7298, J1050, J7300, J7301, J7303, J7304, J7306, and J7307 • S4981, S4989, and S4993

CPT-4 Code Description Summary
• 11976, 11980-11983, 57170, 58300, 58301, 58565, 58600, 58605, 58611, 58615, 58661, 58671, and 96372
Diabetes Screening • 82947 and 83036
DXA Scan • 77080
Global OB-Covered Well-Woman Visits • 59400, 59425, 59426, 59430, 59510, 59610, 59614, 59618, and 59622
Glucose Screening • 82950 and 82951
Gonorrhea Screening • 87850, 87590, and 87591
Hepatitis B Virus Infection Screening for Pregnant Female • 87340
Hepatitis C Screening • 86803
HIV Screening and Counseling • 86689, 86701-86703, 87390, and 87534-87536 • G0432-G0435
HPV DNA Testing • 87620-87625
Iron Deficiency Anemia Screening • 80055, 85013, 85014, 85018, 85025, and 85027
Rh(D) Incompatibility Screening in Pregnant Female • 86901
STI Counseling • 86593, 86695, and 86696 • G0445
Syphilis Infection Screening • 86592 and 86780
Well-Woman Visits • S0610, S0612, and S0613

APPENDIX 8
VERMONT BLUEPRINT PPPM COMMON ATTRIBUTION ALGORITHM
COMMERCIAL INSURERS AND MEDICAID

1. The look back period is the most recent 24 months for which claims are available.

2. Identify all members/beneficiaries who meet the following criteria as of the last day in the look back period:
   - Female, aged 15 – 44 years;
   - Reside in Vermont for Medicaid (and Medicare);
   - Employer sitused in Vermont or member/beneficiary residing in Vermont for commercial insurers (payers can select one of these options);
   - The insurer is the primary payer, or (for Medicaid) the beneficiary is a dual Medicaid/Medicare beneficiary without a commercial insurer as the primary payer.

3. For products that require members/beneficiaries to select a primary care provider, attribute those members/beneficiaries to that provider if the provider is in a WHI-recognized practice.

4. For other members/beneficiaries, select all claims for beneficiaries identified in step 2 with the following qualifying CPT Codes in the look back period (most recent 24 months) for women's health providers included on WHIP payment rosters, <u>where the practice has signed the self-attestation document for participation in the Blueprint Women's Health Initiative and the provider's credential is as a doctor of medicine, doctor of osteopathic medicine, nurse practitioner, certified nurse midwife, or physician assistant.</u>

CPT-4 Code Description Summary
PCMH & WHI Codes
Evaluation and Management - Office or Other Outpatient Services • New Patient: 99201-99205 • Established Patient: 99211-99215
Consultations - Office or Other Outpatient Consultations • New or Established Patient: 99241-99245
Nursing Facility Services: • E & M New/Established patient: 99304-99306 • Subsequent Nursing Facility Care: 99307-99310
Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Service: • Domiciliary or Rest Home Visit New Patient: 99324-99328 • Domiciliary or Rest Home Visit Established Patient: 99334-99337
Home Services • New Patient: 99341-99345 • Established Patient: 99347-99350

CPT-4 Code Description Summary
Prolonged Services – Prolonged Physician Service With Direct (Face-to-Face) Patient Contact • 99354 and 99355
Prolonged Services – Prolonged Physician Service Without Direct (Face-to-Face) Patient Contact • 99358 and 99359
Preventive Medicine Services • New Patient: 99381–99387 • Established Patient: 99391–99397
Counseling Risk Factor Reduction and Behavior Change Intervention • New or Established Patient Preventive Medicine, Individual Counseling: 99401–99404 • New or Established Patient Behavior Change Interventions, Individual: 99406-99409 • New or Established Patient Preventive Medicine, Group Counseling: 99411–99412
Other Preventive Medicine Services – Administration and interpretation: • 99420
Other Preventive Medicine Services – Unlisted preventive: • 99429
Newborn Care Services • Initial and subsequent care for evaluation and management of normal newborn infant: 99460-99463 • Attendance at delivery (when requested by the delivering physician) and initial stabilization of newborn: 99464 • Delivery/birthing room resuscitation: 99465
Federally Qualified Health Center (FQHC) – Global Visit ***(billed as a revenue code on an institutional claim form)*** • 0521 = Clinic visit by member to RHC/FQHC; • 0522 = Home visit by RHC/FQHC practitioner • 0525 = Nursing home visit by RHC/FQHC practitioner
WHI Unique Codes
Asymptomatic Bacteriuria Screening in Pregnant Female • 87081, 87084, 87086, and 87088
Breast and Ovarian Cancer Susceptibility, Genetic Counseling and Evaluation for BRCA Testing • 96040
Breast Cancer Screening • 77052, 77055-77057, and 77063 • G0202
Breast Feeding Support, Supplies and Counseling • A4281-A4286

CPT-4 Code Description Summary
• E0602-E0604 • S9443
Cervical Cancer Screening • 88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, and 88175 • G0101, G0123, G0141, G0143-G0145, G0147, and G0148 • Q0091
Chlamydia Screening • 86631, 86632, 87110, 87270, 87490, 87491, and 87800
Contraceptive Methods • A4261, A4264, A4266, and A4268 • J7297, J7298, J1050, J7300, J7301, J7303, J7304, J7306, and J7307 • S4981, S4989, and S4993 • 11976, 11980-11983, 57170, 58300, 58301, 58565, 58600, 58605, 58611, 58615, 58661, 58671, and 96372
Diabetes Screening • 82947 and 83036
DXA Scan • 77080
Global OB-Covered Well-Woman Visits • 59400, 59425, 59426, 59430, 59510, 59610, 59614, 59618, and 59622
Glucose Screening • 82950 and 82951
Gonorrhea Screening • 87850, 87590, and 87591
Hepatitis B Virus Infection Screening for Pregnant Female • 87340
Hepatitis C Screening • 86803
HIV Screening and Counseling • 86689, 86701-86703, 87390, and 87534-87536 • G0432-G0435
HPV DNA Testing • 87620-87625
Iron Deficiency Anemia Screening • 80055, 85013, 85014, 85018, 85025, and 85027
Rh(D) Incompatibility Screening in Pregnant Female • 86901
STI Counseling • 86593, 86695, and 86696 • G0445
Syphilis Infection Screening • 86592 and 86780

CPT-4 Code Description Summary
Well-Woman Visits • S0610, S0612, and S0613

5. Assign a member/beneficiary to the practice where s/he had the greatest number of qualifying claims. A practice shall be identified by the NPIs of the individual providers associated with it.

6. If a member/beneficiary has an equal number of qualifying visits to more than one practice, assign the member/beneficiary to the one with the most recent visit.

7. Insurers can choose to apply elements in addition to 5. and 6. above when conducting their attribution. However, at a minimum use the greatest number of claims (5. above), followed by the most recent claim if there is a tie (6. above).

8. Insurers will run their attributions at least quarterly. Medicaid plans to continue to run their attribution monthly.

9. Insurers will make PPPM payments at least quarterly, by the 15th of the second month of the quarter. Base PPPM payments on the most current PPPM rate that insurers have received from the Blueprint prior to check production.

10. For insurers paying quarterly: if a new practice goes live in the third month of a quarter, add that practice to the attribution and payment schedule for the subsequent quarter. Payment would be made for the first month of participation, but it would be based on the attribution for the subsequent quarter and would be included in the subsequent quarter's payment. For example, if a practice becomes recognized on 3/1/2013, payment for 3/1/2013 through 6/30/2013 would occur by 5/15/13.